Singletrack Health, PC

RELEASE OF INFORMATION

Medical Record#_____

(Required items are in BOLD print. *Please do not use correction fluid or tape)*

Patient Name:_____ **Date of Birth:**_____

Previous Name(s):_____ **Social Security #:**_____

Address:_____

City/State/Zip_____**Phone:**_____

I, _____**authorize**_____

Name of Patient or Legal Representative ***Name of Organization/Provider to Release Information***

Address:_____

Phone:_____ **Fax:**_____

to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

Singletrack Health, PC
107 W Main Street, Ste 2
Marquette, MI 49855-4651
Phone: 906.662.4070 Fax: 906.662.4091

1. Specific information to be disclosed *(check all that apply)*

_____Progress Notes _____Substance Abuse
_____Emergency Room Report _____Psychological Evals _____Radiology/X-ray Films _____Consultation Reports
_____Discharge Instructions _____Lab Reports _____Radiology/X-ray Reports _____Operative Procedures
_____History and Physical _____EKG/Stress Test _____Home Health _____Discharge Summary
_____Other_____

For the following date(s) of treatment or medical condition(s)
With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here:_____
_____

2. I am requesting this information be released for the following purpose:

_____Continued Care ____Insurance Claim _____Personal Use _____Attorney Review

____Other _____

3. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
4. I understand there may be a fee to process this release of information.
5. This authorization will automatically expire on: or one year from the date of my signature.
6. Singletrack Health, PC will not condition my continued treatment upon my signing this authorization, except for research-related treatment.
7. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.
8. I hereby agree to indemnify and hold Singletrack Health, PC, their employees, and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

_____

Patient's or Legal Representative's Signature* *Date*

_____

Relationship if Other Than Patient *Witness*

REASON PATIENT IS UNABLE TO SIGN: _____Minor _____Deceased _____Other_____

AUTHORITY ATTACHED ***(In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization.***